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Specialty Spotlight



Bremerton, WA—LT Aaron Chambers, Podiatrist, performs an examination during the COVID-19 pandemic.

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Newsletter Staff
LCDR C. Hartley
LT J. Becker
LT J. Jacesko
LT K. Maldarelli
LT R. Rabulan



FROM THE MSC DIRECTOR



Greetings MSC leaders,

Thank you for your *Leadership Through Service*.

Nearly a year ago, shortly after we celebrated our 72nd birthday as a Corps, I was honored to become your Corps Chief. In my first Rudder column, I wrote, "...I know we face a changing sea state that brings uncertainty..." but the following fundamental principles will guide us forward: a diverse team that is more adaptable, innovative, flexible, and responsive; our MSC core values of heritage, excellence, and integrity will continue to be our foundation; and each of us will deliver *Leadership Through Service* to accomplish our missions. While no one could have imagined last year just how much our sea state would change and our current levels of uncertainty, I cannot thank each of you enough for leading by these principles and making a difference every day.



Thank you. The last six months have presented obstacles in the form of a global pandemic we could not have dreamed of. But there are none better than Navy Medicine's 3,100 MSCs to lead us through this crisis. You have responded to the call when your country needed you the most. You have been leaders in innovation across all 31 specialties - moving us forward years ahead of any plan. You have been bold and have taken calculated risks, while bringing the best and brightest together, regardless of specialty. Thank you.

Thank you. During this pandemic, we began long overdue conversations on racial equality, inclusion, and diversity. For many of us, including myself, these conversations are first about listening. Now, across our commands, we have started enduring conversations, as the SG has requested, so that we can remove barriers to inclusiveness and leverage our diversity to become a stronger medical force. Yes, these necessary conversations can be difficult, but they are vital to identifying and eliminating individual, institutional, and systemic racism and discrimination in our force. Thank you for being the leaders our Navy needs to build understanding, trust, and connection.

Thank you. The challenges and uncertainty that lie before us can be overwhelming, but I could not be more proud of how each of you has lent a listening ear, extended a helping hand, or provided a supportive shoulder. This is the essence of who we are - actions seen and unseen that help each other. Thank you for taking care of your Shipmates. In the coming weeks, we will celebrate our 73rd Birthday. Yes, it will look different than before, but know it is a celebration of our history, all that you are doing today, and our very bright future. Thank you for your *Leadership Through Service*.

Ugh #19



Click the link below for
board preparation:

[Board Preparation](#)

<https://www.public.navy.mil/bupers-npc/boards/activedutyofficer/Pages/default.aspx>

FROM THE CORPS CHIEF'S OFFICE *BRAVO ZULU SHIPMATES!*



FY-21 Reserve Captain MSC Selectees

Hall, Billy F.

Avalos, Amada Y.

Buni, Glenn G.



FY-21 Reserve Commander MSC Selectees

Lefevre, James R.

Strickland, Timothy R.

Anderson, Laura J.

Deshazo, Matthew W.

Holuby, Ronnie S.

Dejesus, John F.

Zweiback, Damita J.

CUSTOMS AND HERITAGE

THE PLANKOWNER CHRONICLES: NAVY MEDICINE IN THE MEDICAL SERVICE CORPS BIRTH YEAR

BY ANDRE B. SOBOCINSKI, HISTORIAN, BUMED

The year is 1947 and the Navy's newest—and most unique—staff corps is born with the passage of the Army-Navy Medical Service Corps Act.

The year saw the establishment of the Department of Defense. Heading this new agency was the former Secretary of the Navy, James Forrestal. Forrestal was a tireless patriot whose work ethic ultimately led to a premature death from the VIP suite at the National Naval Medical Center (NNMC) in Bethesda, MD. A year before his death, Forrestal established the "Committee on Medical and Hospital Service of the Armed Forces" as a means of exploring unification of the service medical departments.

Veterans from World War II were ever-present throughout the United States. Remarkably, one in ten Americans living in 1947 was a World War II veteran. Forty-nine percent of all college students in 1947 were World War II veterans and all 251 Medical Service Corps plankowners held this distinction.

At the helm of the Navy Medical Department was Rear Adm. Clifford Swanson, who was entering his second year as Surgeon General of the Navy. Swanson's task was no more than to ensure that Navy Medicine was ready to meet the requirements of modern war despite the post-war cut-backs. This was the largest demobilization in U.S. history.

Over three million naval officers and enlisted were released or discharged between 1945 and 1947. Navy

Medicine, too, was rapidly shrinking in size. At its peak in July 1945, Navy Medicine comprised over 163,000 uniformed personnel. Between July 1945 and July 1947, the Navy Medical Department alone shrank to one-seventh of its former size. Everything that the war necessitated—base and fleet hospitals, medical storehouses, dispensaries, convalescent facilities and reserve training units—were gone. And at Navy's CONUS and OCONUS Medical Treatment Facilities (MTFs) there was a 73% decrease in authorized hospital beds, and with it a 73.5% decrease in the patient census in that two-year span.

By the end of 1947, the Navy was down to two hospital ships in a fleet that once numbered 15. USS *Haven* (AH-12) and USS *Benevolence* were decommissioned at the end of 1947, leaving only USS *Consolation* (AH-15) and USS *Repose* (AH-16) in commission during the period leading up to the Korean War.

Though Navy Medicine's identity took a hit after the war, the period of demobilization forced the Medical Department to refocus on its foundational mission. The Navy began placing greater emphasis on the quality of medical and dental care, investing in new preventive and therapeutic medicine programs, and improving and exploring new training initiatives, all while continuing to ensure the readiness of the personnel that they served.

(Continued on next page)



Naval Hospital St. Albans in 1947.

CUSTOMS AND HERITAGE

THE PLANKOWNER CHRONICLES: NAVY MEDICINE IN THE MEDICAL SERVICE CORPS BIRTH YEAR

BY ANDRE B. SOBOCINSKI, HISTORIAN, BUMED



Hospital ship *Benevolence* in 1947.

There was some growth in the Medical Department. The year saw the construction of the first dependent care facilities in the Navy, as well as new advances in medical administration, prosthetics, occupational and physical therapy, dietetics, and psychology at Navy hospitals. Amputee centers at Naval Hospital Mare Island, CA, and Philadelphia, PA, were expanded. Both facilities were equipped with special prosthetic laboratories for manufacturing artificial limbs and devices.

In addition to being home to the "President's Hospital," NNMCMC was also headquarters for many of Navy Medicine's education and training activities. Among them was the Naval Dental School, the Naval School of Hospital Administration and the Naval Medical School, which operated most of the Navy's technician "C" schools.

Advanced training for what was still termed "Corpsmen on Independent Duty" was given at the Hospital Corps School in Portsmouth, VA. And for Corpsman-Submariners, there was the Submarine School for Pharmacist's Mates in Groton, CT. The Navy operated its "A" schools in Great Lakes and San Diego. Hospital Corps-

men would still be known as "Pharmacist's Mates" until 1948.

Medical research continued to make inroads in 1947. Clinical research programs sprouted up at many naval hospitals. In 1947, four years after the Navy's adoption of penicillin, several hospitals began exploring new uses for antibiotics in treating TB, venereal diseases, and other ailments.

The Naval Medical Research Institute (NMRI) in Bethesda, MD, served as the headquarters command for Navy Research and Development. Its research network expanded across the globe and included infectious disease labs Naval Medical Research Unit (NAMRU) No. 1, Berkeley, CA; NAMRU No. 3, Cairo, Egypt; NAMRU No. 4, Dublin, Georgia; and the operational labs Naval Medical Field Research Laboratory (NMFRL), Camp Lejeune, NC; Naval Submarine Medical Research Laboratory (NSMRL), New London, CT; as well as the laboratory at the Naval School of Aviation Medicine in Pensacola, FL.



MSC Detailers

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FROM THE DETAILERS

-NPC PCS COVID-19 Fact Sheets: <https://www.public.navy.mil/bupers-npc/organization/npc/publicaffairs/news/Pages/default.aspx>

-MyNavyPortal: <https://my.navy.mil/index-lb.html> weekly conditions update and PCS waiver.

-NAVADMINs: <https://www.public.navy.mil/bupers-npc/reference/messages/NAVADMINs/Pages/default.aspx>

-ALNAVs: <https://www.public.navy.mil/bupers-npc/reference/messages/ALNAVs/Pages/default.aspx>

-HCA Downstream Friendly reminder: Due to billet funding changes, MSC HCA downstream list will be suspended until billet funding is stabilized. All HCA officers are asked to contact the HCA detailer /CDR Janiese Cleckley when they are 12 months out from projected rotation date to discuss available follow on assignments.

-Role of Detailer: Detailers advocate for members and provide professional insight and advice to aid in career success. Detailers for all Navy communities work at Navy Personnel command (PERS). Detailers are part of review chain for orders, retirements, separations but are not final approval authority.

Detailers can only affect your record in three ways:

1. Enter some, but not all additional qualifying designators (AQDs). AQDs become part of special qualification section on your officer summary record (OSR).
2. Negotiate and write orders, which become part of your performance summary record (PSR).
3. Assist in processing extension requests, which extend personnel and change end date on PSR.

-Officer Record Update: <https://www.public.navy.mil/bupers-npc/career/recordsmanagement/militarypersonnelrecords/Pages/OffRcdUpdate.aspx>

-NEW SCIENTIST & PA DETAILER:

PERS-4415 welcomes LCDR Ryan Aylsworth who is coming to us after completing a tour as Operations Officer at Navy Environmental and Preventive Medicine Unit SEVEN, Rota, Spain. He has turned over with CAPT Steve Griesenbeck. His phone number is 901-874-4115 and his email address is ryan.j.aylsworth@navy.mil. CAPT Griesenbeck is transferring to Navy Medical Research Unit TWO detachment Thailand where he will report as the Program Manager for Malaria research. We wish him and his family fair winds and following seas!

-ORDERS RELEASE UPDATE:

Orders are currently being released through Feb 2020. Due to high volume of order modifications, order processing/release times have been extended. Appropriate adjustments will be employed if lead times affect mission/PCS execution. Retirement/resignation/ accession orders are being released nine months prior to PRD for OCONUS and six months prior to PRD for CONUS personnel.

-NEGOTIATING ORDERS:

We are currently focusing our efforts on members directly impacted by conditional PCS stop. If you are one year or less away from your projected rotation date (PRD) and have not already begun discussing the PCS plan with your Specialty Leader and Detailer, please reach out to them to initiate communication.

-Useful Websites:

-Centers For Disease Control: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>

-Joint Travel Regulation (JTR): https://www.defensetravel.dod.mil/site/news_Coronavirus.cfm

-DoD COVID-19 Policies: <https://www.defense.gov/explore/spotlight/coronavirus>

-USTRANSCOM Defense Personal Property: <https://www.ustranscom.mil/dp3/index.cfm> or <https://www.ustranscom.mil/dp3/advisory.cfm> (Click: PP Advisories, most recent at bottom)

-This 6 question survey is available to provide PERS 4415 feedback on strengths and opportunities to improve: <https://surveys.max.gov/index.php/454228>

RESERVE UPDATE

CAPT KATHERINE ORMSBEE, MSC, USN
RESERVE AFFAIRS OFFICER, MEDICAL SERVICE CORPS

Operational Health Support Unit (OHSU) Pensacola

By: CAPT Efstratios Lagoutaris

“Small, but mighty” is perhaps the best way to describe Operational Health Support Unit (OHSU) Pensacola! We stand ready to deliver a rapidly, deployable ready medical force to support contingency, humanitarian, and disaster emergency operations across the globe anytime, anywhere!

Led by Commanding Officer, CAPT Ramesh Darvasula, and Command Senior Chief, HMCM James Long, OHSU Pensacola is directly responsible for providing the medical and dental support required to keep the world’s greatest Navy ready for any mission. This is accomplished through the tireless work of 105 Officers and 97 Sailors in nine detachments across five southern states and two Reserve Component Commands. With a mix of medical specialists across all Corps, alongside dedicated Corpsmen, OHSU Pensacola provided \$120,000 in medical support and \$28,000 in dental support to nine NOSCs and attached personnel before the Coronavirus pandemic halted operations. Cross-assigned members comprise a Virtual Detachment that provides support throughout the enterprise. 55 members of OHSU Pensacola were mobilized in support of the fight against COVID-19, with an active role in every major area of operations.

The Medical Service Corps (MSC) remains an indispensable asset to Navy Medicine and OHSU Pensacola as medical professionals, administrative experts and leadership examples. OHSU Pensacola has 10 MSC Officers representing a variety of subspecialties, including three Pharmacists, one Dietitian, one Health Care Administrator, one Physician Assistant, one Occupational Therapist, one Environmental Health Officer, and two Podiatrists. Eighty percent of OHSU Pensacola’s MSC is active in leadership and administrative functions across the Command. Currently, MSC Officers serve as Command with one as Headquarters Detachment OIC, two as Detachment OIC, one as Command FITREP Coordinator, one as Command Awards Officer and two as Command Manpower Officer and Assistant. The MSC is led by CAPT Stratis Lagoutaris, as the current Director for Administration. CDR(sel) Timothy Strickland, our Command Manpower Officer, was recently selected to lead the charge on Career Development Boards for Reserve MSC personnel across all of Navy Medicine. Another MSC Officer is currently serving on mobilization orders OCO-NUS.

OHSU Pensacola stands ready to face the changes in Navy Medicine and challenges around the globe, serving with Honor, Courage and Commitment.

BALTOPS 2020 Exercise



BALTOPS is an annual maritime exercise, designed to enhance interoperability, flexibility, and demonstrate resolve among allied and partner forces in defending the Baltic region. Twenty-eight air and 28 maritime assets from 17 NATO and 2 partner nations participated in the live training event that began on June 7th concluded June 16th. Participating nations included Canada, Denmark, Estonia, Finland, France, Germany, Greece, Italy, Latvia, Lithuania, the Netherlands, Norway, Poland, Portugal, Spain, Sweden, Turkey, the U.K. and the U.S.

This year marks the sixth STRIKFORNATO-led BALTOPS and the first entirely maritime exercise, which ensured the health and safety precautions for all participating forces. For the first time, U.S. SIXTH Fleet stood up a backup Battle Watch within the Maritime Operations Command Center (MOC) in Naples, Italy.

Serving as the opening Battle Watch Captain for the MOC was reservist LCDR Steven Castle, MSC/HCA/FMF/POMI who is serving CNE/CNA/C6F as an N51 Country Action Officer under ADSW orders. “Due to COVID19, we wanted to test our ability to standup a fully capable BWC to support a major exercise. This we did”. The objective was to establish communications throughout exercise via J-CHAT, BICES, SIPR, and APAN tools and monitor message traffic against injects. In addition, we performed daily comms checks with joint force assets at sea. During the exercise, SACEUR GEN Wolters toured the MOC where LCDR Castle provided a short brief on the Battle Watch operations.

Our ability to carry out an exercise of this size and scope of BALTOPS during a global pandemic is a strong testimonial to the capabilities of NATO and partner forces.

Questions or comments? Email us at usn.ncr.bumedfcbva.list.msc-corps-chiefs-office@mail.mil.

SPECIALTY SPOTLIGHT

PODIATRY (1892)

CDR IAN McGUINNESS, SPECIALTY LEADER

LCDR CAMILLE RYANS, ASSISTANT SPECIALTY LEADER (AUTHOR)



HISTORY

From humble beginnings, as hospital-volunteer specialists (Naval Reserve Officers) at Navy Training Centers and Marine Corps Recruit Depots during World War II, Navy Podiatrists have evolved into indispensable members of the Medical Service Corps and Navy Medicine. The first Navy Podiatrist was Commander William Woolf, commissioned in 1942. Podiatry became a Medical Service Corps subspecialty on 3 November 1953. Our contributions are essential to fleet and family readiness.



Las Vegas, NV—Navy Podiatrists attend the American College of Foot and Ankle Surgeons Annual Scientific Conference.

MISSION ESSENTIAL

Podiatrists are physicians specializing in the medical and surgical treatment of the foot and ankle. Navy Podiatrists serve a vital role in the patient care team, and treat active duty, reservists, retirees and dependents of all ages. Podiatrists work in clinical settings and in the Operating Room, performing surgical procedures such as musculoskeletal deformity correc-

tions, tendon and ligament repair, soft tissue debridement and fixation of fractures. Podiatrists also have admitting privileges and treat inpatients. Additionally, as foot and ankle experts, Podiatrists work regularly with Physical Therapists, Interventional Radiologists, Sports Medicine Physicians and Orthotists to alleviate pain and regain patient's functionality after injuries and operative interventions.



Afghanistan - CDR Monique Gouridine-Shaw applies a Hoffman External Fixator for a patient at the National Police Hospital.

SERVING ON THE FRONTLINES

Currently, there are 27 active duty Navy Podiatry billets. Podiatrists are stationed at a majority of the large military treatment facilities (MTFs) in the United States. Overseas billets include Sigonella, Guam, Yokosuka, and Okinawa. Temporary duty assignments include Guantanamo Bay, Djibouti, Bahrain, Rota, Sasebo, Iwakuni and Diego Garcia. Additionally, Navy Podiatrists have recently served aboard the USNS *Mercy*, providing medical support for humanitarian assistance missions. Deployments include Iraq and Expeditionary Medical Force platforms in support of the COVID-19 pandemic.

(Continued on next page)

Academic Map

4 years

Bachelor's Degree

4 years

Doctor of Podiatric Medicine
National Board Examinations Parts I and II

3-4 years

Podiatric Medicine and Surgery or Podiatric Medicine and Surgery with Reconstructive Rearfoot/Ankle Surgery Residency
State Licensure- National Board Examination Part III

1-2 years

Fellowship (optional): Foot and Ankle Surgery & Reconstruction, Research, Sports Medicine, Diabetic Limb Salvage, Complex Limb Preservation, Dermatology

Board Qualification/Certification: American Board of Podiatric Medicine; American Board of Foot and Ankle Surgeons

Subspecialty Code: 1892

AD End-strength: 33

AD Billets: 27

Billet Types

MTF: 23

USM: 2

Joint Forces: 2

SPECIALTY SPOTLIGHT



MCAS Miramar, CA (Pictured L-R): Podiatrists LT Corey Housepian, LCDR Nhu Do, and LT Alexander Button participate in the SoCal MSC Symposium.

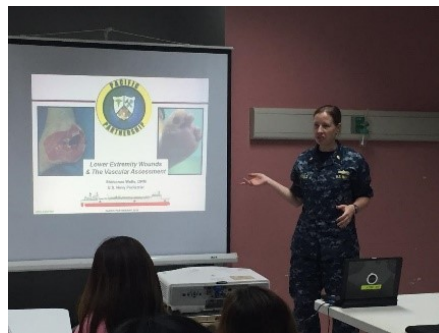
LEGACY

As Navy Medicine front-runners, members of the podiatric sub-community have served in competitive leadership, executive, and academic capacities. Accomplishments include Naval War College, United States Army Command and General Staff College, and Legislative Program Fellow. Navy Podiatrists have also held positions as Executive Officer, Officer-in-Charge, Director for Administration, Director of Healthcare Business, Director of Surgical Services, consultant to the White House Medical Unit, Department Head, and Division Officer.

Navy Podiatry is a rewarding career that affords opportunities for advanced training, such as Duty Under Instruction, and the potential to establish a broad, busy clinical and surgical practice. Members of the sub-community also benefit from unique opportunities in academia, including surgical and clinical professorships.



Podiatrists have published multiple scientific articles in orthopedic and podiatric peer-reviewed medical journals, including *The Journal of Bone & Joint Surgery* and *The Journal of Foot & Ankle Surgery*. In addition, Navy Podiatrists volunteer as attending staff to Podiatrists in training. Residency rotation agreements have been established between MTFs and The University of Florida Health System, Chino Valley Medical Center, Mount Sinai Hospital, Madigan Army Medical Center, and Scripps Mercy Hospital. Active duty Nurse Practitioner students, Army Medics, Sports Medicine Fellows and National Japanese Physician Program Interns also participate in clinical and surgical rotations with Podiatrists.



Pacific Partnership Deployment - LCDR Shevonne Wells delivers a specialty workshop for host nation healthcare providers.

Patient demographics differ from one command to another, and Podiatrists have a wide scope of practice, spanning from the toes to leg, and, in five states, the hand. This mandates that Podiatrists stay abreast of cutting-edge research and techniques in order to render up-to-date treatments. From the onset of the COVID-19 Pandemic, Podiatrists have been instrumental in the increased usage of telemedicine and have innovated new policies and procedures for long-term utilization.



Djibouti - CDR Ian McGuinness, Podiatry Specialty Leader, on assignment in the Horn of Africa.



Subspecialty Code: 1892

AD End-strength: 33

AD Billets: 27

Billet Types

MTF: 23

USM: 2

Joint Forces: 2

INNOVATION: A NECESSARY LEADERSHIP SKILL

BY: LCDR ADAM PRESTON, MSC, OD, MHA, FAAO

The word *innovation* is everywhere – journals, magazines, best-selling books, even mission & vision statements. Furthermore, the Promotion Board Convening Order and 5.0 Fitness Report grades emphasize the importance of innovation and efficiency. Innovation must be a key consideration for clinical operations, business processes, and operational efforts to be successful. However, the very concept of innovation is at risk unless we take deliberate action to define, embrace, and embed it into every department and division within Navy Medicine.

What Is Innovation?

As Samet and Smith describe, not everything that produces change for the better is innovation¹. When defining something, it can be useful to describe what it is *not*. Think about three very important ways to improve an organization: consistent execution, incremental improvement, and selective innovation.

Consistent Execution means performing tasks with reduced variation. Sometimes we know what we need to do but are just not doing it 100% of the time (e.g. hand washing). Improving execution definitely increases value, but it is not innovation.

Incremental Improvement is central to Navy Medicine's success in delivering higher-quality care while reducing costs. Improving workflows and removing waste can result in tremendous efficiency improvements and indeed often requires creative thinking. Many may be familiar with Lean philosophy/Continuous Process Improvement – especially as it relates to earning Green/Black Belt AQDs. However, while some people refer to this as “little ‘i’ innovation” (in contrast to “Big I Innovation” below), it is not by itself true innovation.

Selective Innovation is novel (to the environment), intentional, non-incremental (represents a shift visibly different from the past), deployed and an impactful improvement. It is a radical positive change in a service or product often accompanied by a new way of thinking about measuring success. It bucks the status quo and eschews incrementalism. Selective innovation by its nature is disruptive. It must be given room to grow and is cultivated in a trial-and-error environment where failure is common and success is rare and revolutionary. It is a result of seeing, understanding, and thinking about the world in ways that are different than before, generating a new product, service, framework, process, task, or method that adds value and *breaks from the status quo*.

In fact, if leaders aren't careful, too much emphasis on “maximizing efficiency” and “getting it right the first time” can stifle true innovation – leaving no room for creativity or allowance for trial and error. Innovation is also context-dependent: if a process or product used elsewhere is adopted in a new way or into a new organization, this also constitutes innovation. For instance, innovation occurred when Navy Medicine adopted Toyota's Lean methodology and applied it to healthcare; Line Officers are looking at Carnival Cruise Line's best practices for maintenance. A remote Branch Health Clinic's novel decision to incorporate automated medication cabinets (e.g. Pyxis/PickPoint) to increase after-hours pharmaceutical capability is another example. The current COVID-19 crisis gripping our Nation is sure to produce innovative solutions that should be analyzed and considered for reproduction.

Innovation and the MHS Environment

The organizational structure and culture of the Military Health System represents a dichotomy of traditionalism and innovation. Ingrained in its members are traditions, customs, and bureaucracy, not only by each component service, but also in the medical practice writ large. Unfortunately, bureaucratic rules can stifle innovation and adoption of new practices. Take the case of Information Technology: the MHS must not only abide by HIPAA/HITECH rules, but since medical information is stored on government servers, must abide by a myriad of additional requirements. Many computers that power healthcare equipment may not meet Department of Defense requirements (e.g. specific antivirus software, manufacturer's proprietary software, lengthy approval processes), and therefore may not be allowed on government networks. Collected images & data may have to be physically printed and scanned or burned to a CD in order to transfer the information into the medical record, an incredibly inefficient (and quality-degrading) process.

(Continued on next page)

INNOVATION: A NECESSARY LEADERSHIP SKILL

BY: LCDR ADAM PRESTON, MSC, OD, MHA, FAAO

Financial constraints can also restrict innovation. Funds are appropriated by Congress and distributed to the various commands around the beginning of the fiscal year, and unused funds are reclaimed at the end of the fiscal year. Commands are often unable to retain or save from year to year and must get special permission to make large purchases; if funds are not spent completely, funding for subsequent years may be reduced. This results in an environment where funds are saved scrupulously for nine months (“in case we need it for something”) but spent rapidly in the last three months (“use it all now”). To further complicate matters, Continuing Resolution funds are often piecemealed to the services throughout the year, preventing proper planning and utilization of appropriated funds.

One reason for standardization and bureaucracy stems from the frequent rotation of staff, as most active duty personnel rotate every 2-4 years by changing positions, locations, or both. This necessitates uniformity across the MHS so that personnel can “hit the ground running” when they transfer to a new unit, clinic, or hospital. Frequent rotation also means individuals not transferring often have to find ways to “pick up the slack” until the replacement arrives and is up to speed. These same personnel can be deployed to new environments on short notice. However, this uncertainty also requires innovative solutions in unknown and arduous environments

Nevertheless, the ideas of traditional hierarchy and innovation need not be mutually exclusive. Military leaders are taught that one of the most effective ways to lead is by providing overall guidance, termed Commander’s Intent, so that subordinates generally know the “5 W’s” of what needs to be accomplished but are not micromanaged in how it gets accomplished. “Commander’s Intent empowers initiative, improvisation, and adaptation by providing guidance of what a successful conclusion looks like. Commander’s Intent is vital in chaotic, demanding, and dynamic environments.”²

Fostering an Environment of Innovation

Organizational and personal dynamic forces often hinder individuals’ ability to respond with nimbleness and agility¹. The status quo is stubborn: an organization (whether it be the MHS as a whole or the smallest division in a branch clinic) requires less energy to keep doing what it has been doing than break out and take a different path. The familiarity of the known almost always trumps the potential benefit of the unknown. On an individual level, the daily grind supersedes “pursuit of the remarkable.” For most of the workday, managers and staff are consumed with urgent (but often unimportant) tasks and meetings that fill their minds and calendars, leaving no space for creative thinking, problem solving, and learning. To top it off, the most productive and competent service members are the ones tasked to take on more; remarkably, they are intentionally penalized for good performance. These are the same people who are most likely to innovate but are stretched to the maximum each day, resulting in a huge opportunity cost of creative work lost because it was never started.

So how can the MHS foster innovation at the command, department, and division levels?

Innovative leaders take ownership of their domain. Naval Officers are appointed to lead. Even in the absence of having a specific title, as with *Executive Officer* or *Director*, an officer can affect positive change in their area of responsibility (even if they do not have any direct reports). Innovative MSC officers learn the SG’s, Corps Chief’s, and their CO’s *Commander’s Intent* and start innovating using the authority afforded them when they took their oath of office. They don’t wait for permission or prodding from their superiors; many successful innovations start out as unsung side projects not mandated (or even conceived of) from the top³. Deckplate leaders know their area of responsibility (AOR) better than anyone else, so who better to jumpstart its improvement?

Consider: where does innovation sit on the organizational chart (and on one’s calendar)? Leaders should consider how they are prioritizing innovation in their AOR, and that level of importance reflects to their subordinates. Staff will see what is important to a leader by how they spend their limited time and energy. Commanding and Executive officers may consider creating a Director of Innovation position equal to other directors (e.g. DFA, DHS, DCSS). Even a small staff could help facilitate large change and emphasize its importance throughout the entire command. “We haven’t done it this way before” is poor justification to not try something new.

INNOVATION: A NECESSARY LEADERSHIP SKILL

BY: LCDR ADAM PRESTON, MSC, OD, MHA, FAAO

“Innovative leaders don’t always need to reinvent the wheel.”

“Each failure must be a learning opportunity.”

Those at lower levels of responsibility (DH/DIVO/Staff Clinician), being closer to the point of service for the patient, have a great opportunity to effect meaningful positive change, but time and resources must be carved out and dedicated to this effort.

Look Outside. Innovative leaders don’t always need to reinvent the wheel. They consider how people in other departments, commands, the civilian healthcare sector, and commercial enterprise deal with similar problems in their AOR. They step back, question their assumptions, reframe the problem, get staff and patient input, and consider novel solutions. They replicate (and tweak where necessary) best practices to best meet the specific requirements of their organization.

Leaders Experiment! They are not afraid of failure. As Samet & Smith point out, sometimes the best, fastest, and least expensive way to figure out if an approach will work is simply to try it¹. If it does not work, innovative officers either tweak and iterate or abandon it. Nothing beats the “friction” of real experience for determining what will work and what will not. Harvard Business professor Clayton Christensen estimates that **95%** of new products that make it to market fail.⁴ If an officer isn’t failing at least some of the time, she or he may not be taking enough risks. Of course, the “*Fail Fast*” philosophy needs to be applied iteratively and judiciously, especially in healthcare. Each failure must be a learning opportunity.

Catalyze the innovation energy that resides in the organization. Potential innovation energy resides in every member; the challenge is how to convert that potential into actual innovation and creation. Samet & Smith argue that “potential energy converted into actual energy begets more conversion in a continuous feedback loop of positive energy.” To unlock this, leadership can sponsor competitions or hold forums for staff in which specific problems are posted with an invitation to submit solutions. A formal process can be devised to judge the entries, and winning teams can be awarded time, training, and financial support to deploy their idea.

Personal Development. Effective innovative leadership is not an inborn trait. Just like learning and improving any skill, it takes intentional effort requiring theoretical learning, real-life application, and frank evaluation. Just as medicine advances, so does leadership theory and practice. Unfortunately, taking the time to reflect and improve on one’s leadership is often one of the first to be sacrificed when “things get busy,” and MSC officers are always “busy.” Therefore, creative and tailored solutions for carving out time to acquire this knowledge are often necessary. Thankfully, the advent of electronic books, audiobooks/podcasts (particularly useful when commuting or during physical training), and distance learning courses have made this easier. A list of recommendations and resources for enhancing one’s personal knowledge of innovative leadership is included below. The local Medical Service Corps Association meetings can also be an excellent place for short but intentional professional development discussion sessions. Invitations to lead discussions can be given to those with experience (e.g. senior MSC, DFA, or Command Master Chief) and recent didactic education (e.g. LTJG right out of MHA program, or a recent JPME graduate). This is a good place for officers to bring their problems, obstacles, and ideas for discussion. The most important thing is overcome the inertia of the *status quo* and start making steps in the right direction.

(Continued on next page)

INNOVATION: A NECESSARY LEADERSHIP SKILL

BY: LCDR ADAM PRESTON, MSC, OD, MHA, FAAO

Conclusion

The Navy Medical Service Corps is unique in that we can leverage our administrative acumen, clinical skills, and scientific expertise to meet the known and unknown challenges ahead with innovation and confidence. As a Corps, we believe the future can be better than the present, and that there is always a better way of doing something. As Naval Officers, we are empowered to enact change for the better to improve the readiness of the fleet, lives of the patients we serve, and staff we serve alongside. The duty of all MSC officers is to recognize both current and future challenges, and identify which positive change approach (consistent execution, incremental improvement, or selective innovation) is necessary, and then carve out time and resources to do it!

Helpful Resources & Recommendations

CNO's Professional Reading Program Books on Leadership, many of which are available free through the Navy MWR Overdrive Collection. For innovation and leadership topics, consider the "[Core Attributes](#)" and "[High Velocity Outcomes](#)" categories, such as: [The Innovator's Dilemma](#) (Christensen), [Outliers](#) and [The Tipping Point](#) (both by Gladwell), [The Checklist Manifesto](#) (Gawande), [Nudge](#) (Thaler & Sunstein) and [Dare to Lead](#) (Brown).

Podcasts on Innovation, including [Harvard Business Review's HBR IdeaCast](#), [NPR's How I Built This](#), and [Freakonomics Radio](#) (among many others).

[The National Defense Strategy](#), [U.S. Navy Strategic Documents](#), [DHA Mission/Vision/Goals/Strategy](#), [BUMED Directives/Instructions/Notes](#), local Commanding Officer (including parent command if applicable) guidance documents.

Keep up to date by checking the latest [NAVADMINs](#) and [ALNAVs](#), in particular anything to do with strategy, enlisted personnel, or promotion boards. It is recommended to check this several times per week.

References

1. Samet KA, Smith MS. Thinking differently: catalyzing innovation in healthcare and beyond. *Frontiers of Health Services Management*. 2016;33(2):3-15.
2. Storlie C. Manage uncertainty with commander's intent'. *Harvard Business Review*. 2010;3.
3. Furr N, Dyer J. *The Innovator's Method: Bringing the Lean Start-Up Into Your Organization*. Harvard Business Review Press; 2014.
4. Noble C. *Clay Christensen's Milkshake Marketing*. Harvard Business School Working Knowledge; 2011.

"As a Corps, we believe the future can be better than the present, and that there is always a better way of doing something."

Updates on the MSC Career Development Board (CDB) Program

By: LCDR Erica Harris, CDB Program Manager

Hello, Fellow MSCs! As the new CDB Program Manager, I would first like to thank the previous CDB Program Manager, LCDR Ann MacDonald, for setting a strong foundation! As we move forward into the next three years, the goals of the program remain as follows: To assist MSC Officers in 1) effectively managing their careers, 2) setting SMART (i.e., specific, measurable, achievable, realistic, and timely) goals, and 3) meeting key career milestones.

Based on community feedback, the CDB Strategic Goal Group team is focusing on the following Lines of Effort (LOEs) to continue elevating the quality of the program:

LOE	Description of LOE	Progress to Date	LOE Members
CDB Tracking	Improve tracking and reporting accuracy of CDB compliance	CDB Tracking: Developed Command Coordinator and Specialty Leader Tracking Spreadsheet – Stay tuned! Coming soon!	Co-Leads: LCDR Larry Middleton LT Jaime “Cris” Zhunepluas
			Group Members: LT Edgar Escobar, LT Michael Wing, LCDR Krystal Glaze LCDR Kristoffer Reyes
Command Co-ordinator and CDB Member Tools	Improve the quality of CDBs by providing tools to CDB Command Coordinators and Board Members	Revamped the MSC CDB milBook page (See here: https://www.milsuite.mil/book/groups/msc-career-development-board-program)	Co-Leads: LT Dan Xu LT Jonathan Gomez-Rivera
			Group Members: LT Megan Hess, LT Owen Pitrone, LT Serge Shkuro, CDR Marjorie Wytzka
MSC Professional Development Tools	Equip individual Officers with tools to succeed	Added five new tools to the JO Seabag – Stay tuned! Coming soon!	Co-Leads: LT Chaselynn Watters LT Andrew Hoff
			Group Members: LTJG Tun Min, LT Peter Mercredi, LT Heather Wallace, LCDR William Agbo, LCDR Michelle Lane
Measures of Effectiveness	Create mechanisms to assess program effectiveness	Created a new individual CDB survey on MAX.gov – Stay tuned! Coming soon!	Lead: LCDR Colleen Cordrick
			Group Members: LT Mary Ehrsam, LT Osaze Uwadia, LT Heather Wallace, LCDR Tara Smallidge, LCDR Pete Walker

What do you need to know? The MSC CDB program continues to grow and develop everyday to meet the needs of our officers.

- Be on the lookout for updated policy, tools, and references over the coming months.
- Visit the milBook page often as it will be the central repository for all things MSC CDB.

For questions regarding the CDB program, please contact LCDR Erica Harris, erica.r.harris@navy.mil or LCDR Larry Middleton, larry.middleton1@navy.mil.

Share your photos, sea stories, and BZs to **THE RUDDER**

Submit them through your chain of command to: [MSC Corps Chief's Office](#)

Questions or comments? Email us at usn.ncr.bumedfcbva.list.msc-corps-chiefs-office@mail.mil.

Healthcare as a High Reliability Organization: An Introduction

By: CDR Sally Kush, CAPT Marc Herwitz, & LCDR Amanda Bradford

Healthcare is a risky business. But does it have to be? It is safer to build a hospital than to receive care in a hospital. This is the premise for what many in healthcare are calling their journey to becoming a High Reliability Organization (HRO). In October of 2014, the Secretary of Defense directed the Military Health System (MHS) to adopt the principles of HROs in an effort to create a culture of safety and quality. The driving force was to lower the occurrence of preventable medical errors, the third leading cause of death after heart disease and cancer, costing the United States \$20.8 Billion per year. These principles are highlighted by Weick & Sutcliffe, in their book *Managing the Unexpected*, which defines HRO this way: "High reliability is when an organization operates under very trying conditions all the time and yet manages to have fewer than their fair share of accidents." Essentially, it is about being able to predict the probability of safety when the consequence of things going wrong is high. This is not a new concept. It originated in the aviation community, a high-risk industry whose probability for experiencing grave consequences has been reduced through the use of HRO principles and is now considered a very safe and reliable mode of transportation.

What does this mean for healthcare? Zero harm to patients and zero harm to staff is the goal. The Institute of Medicine published a seminal report in November 1999 called *To Err is Human: Building a Safer Healthcare System*, which addressed a turning point of focus on the National Patient Safety Goals. It emphasized the fact that healthcare is about people and people make mistakes. The tipping point for high reliability into healthcare started about 20 years ago, when Cincinnati Children's Hospital decided to embark on their journey to provide perfect care. Since that time, they have earned national and international recognition as a model and leader in quality improvement. About half the nation's health care organizations have followed suit and have now started their own HRO journey.

Speaking with Linda Knopes, the Director for Patient Safety of the Puget Sound Region Multicare Health System, she emphasized that healthcare has changed over the years. "It has morphed from being primarily charity based to being run as a business and with the advent of technology and increased complexities, it is easier to do the wrong thing and harder to do the right thing." The journey to becoming more safety conscious (thus more highly reliable) reverses this scenario so that it makes it harder for people to do something wrong and easier for them to do it right as well as recover quicker when things do go wrong. She also shared what MultiCare has been doing to adopt a culture of safety, "A harm event occurs when you have a high-risk situation coupled with a high risk behavior." In order to mitigate risk, certain behaviors need to be employed. Training staff on how to engage in these high reliability behaviors is key to initiating change.

MultiCare has simplified HRO training for all front line and supportive staff by outlining it with the following acronym: **C.A.R.E.**

Communicate Clearly.
Pay Attention to Detail.
Be a Respectful Team Member.
Embrace a Questioning Mindset.

Continued to next page...

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Submit them through your chain of command to: [MSC Corps Chief's Office](#)

Healthcare as a High Reliability Organization: An Introduction

By: CDR Sally Kush, CAPT Marc Herwitz, & LCDR Amanda Bradford

Continued from previous page...

The acronym **C.A.R.E** highlights what to **DO**. Each behavior has a methodology for how it is **DONE**. The following will expound on each behavior.

Communicate Clearly: Ensure that information is communicated correctly and instructions are accurately understood. This language of safety is employed a number of ways: 1) Asking clarifying questions, 2) Using a 3-way repeat back, 3) Using phonetic and numeric clarifications, 4) using SBAR for action, and 5) using standardized handoffs. For example, an **SBAR** for action could be used to communicate a problem to an individual or a group of people by summarizing the **S**ituation, giving pertinent **B**ackground information, demonstrating the **A**ssessment with stated reviews and providing **R**ecommendations for resolution.

Pay **A**ttention to Detail: Be present and stay focused to avoid causing distractions or being distracted yourself. The goal is to avoid unintended slips and lapses. Self-checking using the “head-before-hands” technique **S.T.A.R.**: Stop. Think. Act. Review. Consider this situation: a nurse is in the middle of calculating a dosage and gets interrupted by another staff member asking a question and momentarily loses their train of thought. Before administering the medication, practicing the STAR checklist could prevent a serious mistake.

Be a **R**espectful Team Member: Demonstrate a personal commitment to our patients and families, and our team members. The key to success for this behavior is to be open to checking other people’s work and to be willing for others to check our work. It’s really about helping each other do the right thing. Cross checking each other increases accountability and promotes teamwork. Coaching each other by providing a 5:1 ratio of positive to negative feedback reinforces good habits and extinguishes bad habits.

Embrace a Questioning Mindset: Thinking critically ensures that our actions are the best. This can be done using the following methods: 1) Pause (take a second to think), Question (Ask: does this information make sense to me?) and Confirm (check it out with an independent qualified source); 2) Know Why & Apply by using a variety of error prevention tools such as source policies, procedures, protocols and checklists, especially for long complicated procedures that are beyond what is humanly possible to remember. Also, using safety language when speaking with each other will trigger more analytical thinking.

One of obstacles to achieving a culture of safety is power distance. Leaders fail to see how much power they have. Since power distance is determined by those who are subordinate, leaders need to recognize where power distance exists and ways to minimize it so that everyone feels like a valued member of the organization. Leaders can do this through the distribution of power, and by bringing in subordinates into the decision-making process. They can foster an environment where people feel they can speak up, invite alternative perspectives, and encourage discussion. A culture of safety is where people feel comfortable sharing what they are uncomfortable with. As people feel vested in being part of the solution, they are able to voice their concerns, stating why they are uneasy about a situation and how it may be a safety issue.

What does this mean for Navy Medicine? It means that in order for Navy Medicine to remain cutting edge, it must strive to become a leader in HRO practices. The healthcare environment is a high risk environment, and human error can cause grave harm to people. But, by adopting a high reliability mindset, which combines a “Culture of Trust” with heightened safety awareness, we can reduce errors and raise performance to the highest levels.

Share your photos, sea stories, and BZs to **THE RUDDER**

Submit them through your chain of command to: [MSC Corps Chief's Office](#)

Questions or comments? Email us at usn.ncr.bumedfcbva.list.msc-corps-chiefs-office@mail.mil.

MSCs IN FOCUS

CONGRATULATIONS TO
OUR LOGISTICIAN
AWARDEES!



Junior Logistician of the Year
LT Telia Wright
NMRTC Camp Lejeune



Senior Shore-Based Logistician of the Year
LCDR Macedonio Herrera
NMRTC Jacksonville



**CDR Robert A. Edgar Award for
Military Operational Medical Logistician of the Year**
LT Megan Jones
USMC Special Operations Command

MSCs IN FOCUS



Pensacola, FL: LT James Salassi receives recognition as the Naval Aerospace and Operational Physiologist (NAOP) of the Year from CAPT Brian Bohrer, NAOP Specialty Leader. LT James “SID” Salassi, the Aeromedical Safety Officer attached to Marine Aircraft Group 39 in Camp Pendleton, CA, was recognized for several accomplishments, most notable was his development of an initial Night Vision Device curriculum for the Marine Ground Combat Element. This capability already exists for aircrew, but this new curriculum for ground combat crew will be a force-enabler for the Ground Combat Element.



Cherry Point, NC - Pictured left: LCDR Lindsay Gleason, Clinical Psychologist from NMRTC Cherry Point, educates Sailors and Marines on Mental Health in her video series in observance of Mental Health Awareness Month (May) and PTSD Awareness Month (June). Pictured right: NMRTC Cherry Point celebrates the 122nd Birthday of the Hospital Corps with a birthday cake, as many MSC Officers were prior-HMs.

MSCs IN FOCUS



Fallon, NV - LT Joseph Ichull, Physician Assistant, pictured left, receives the Navy Commendation Medal from CAPT Evan Morrison, Naval Air Station Fallon's Commanding Officer, for his work during the COVID-19 pandemic as the installation's Alternate Public Health Environmental Officer.



Brussels, Belgium (Pictured L-R): MGen Claes, Commandant of the Belgian Defense College, Royal Military Academy, and LCDR Eugene Osborn, POMI. LCDR Osborn successfully completed all requirements of the Advance Staff Course (ASTC) to receive his Master's degree of Arts in Political Science and Military Studies from MGen Claes. The ASTC is a year-long program offered to selected Belgian and International military officers that focuses on the three core competencies of Leadership and Management, Joint Operations, and Strategy and Defense.



Yokota AB, Japan - USFJ Surgeon Cell COVID-19 Task Force Team. Picture (first row): TSgt Teresa L. Antonitis, LtCol Shawn M. Garcia, CAPT Kristin I. Drell. Second row: CAPT Robert J. Lipsitz, LT Niraj Khanal, Industrial Hygiene officer (IHO), TSgt Casey R. Forbes, LT Jessy Calderon (IHO), CAPT Charmagne G. Beckett. First row: SSgt Mitchell R. Dawson, LT Dennis W. Chang, COL Patrick W. Stilley, CAPT Phillip D. Mailloux, LTGen Kevin B. Schneider, CDR Brock J. Johnson, HM1 Mathew C. Swaitek, and MAJ Earl E.J. Thomas.

MSCs IN FOCUS



New Orleans, LA - EMF Mike MSC Officers pose for a photo during their deployment in support of the COVID-19 response. Pictured (L to R): LT Robert Wolfe, HCA/POMI; CDR Marcy Morlock, Director of Administration; LT Alyssa Garofalo, Clinical Psychologist; LT Allison Conforte, Clinical Psychologist.

Got photos?

Route your requests via your chain of command and send them to the Corps Chief's Office with the following information:

1. Location of picture
2. Rank/Full Name/Specialty of all Officers in picture
3. Suggested caption



Frederick, MD - Naval Medical Logistics Command (NMLC) personnel pose for a photo during their award ceremony. Pictured (L-R): HMCM Patrick B. West, NMLC Command Master Chief; CDR Matthew Marcinkiewicz, NMLC Deputy Commander; HM2 Justin Miller; HM1 Franklin Ihama; HM2 Joseph McLaughlin; and, CAPT Steve Aboona, NMLC Commander.

May 2020 Crossword Puzzle

WINNER: LTJG Kionna D. Myles, HCA

Across:

3.) Offers _____ level Joint Professional Military Education (JPME-I) through a set of three courses: Strategy and War (S and W), Theater Security Decision Making (TSDM), Joint Maritime Operations (JMO), offered at multiple locations.

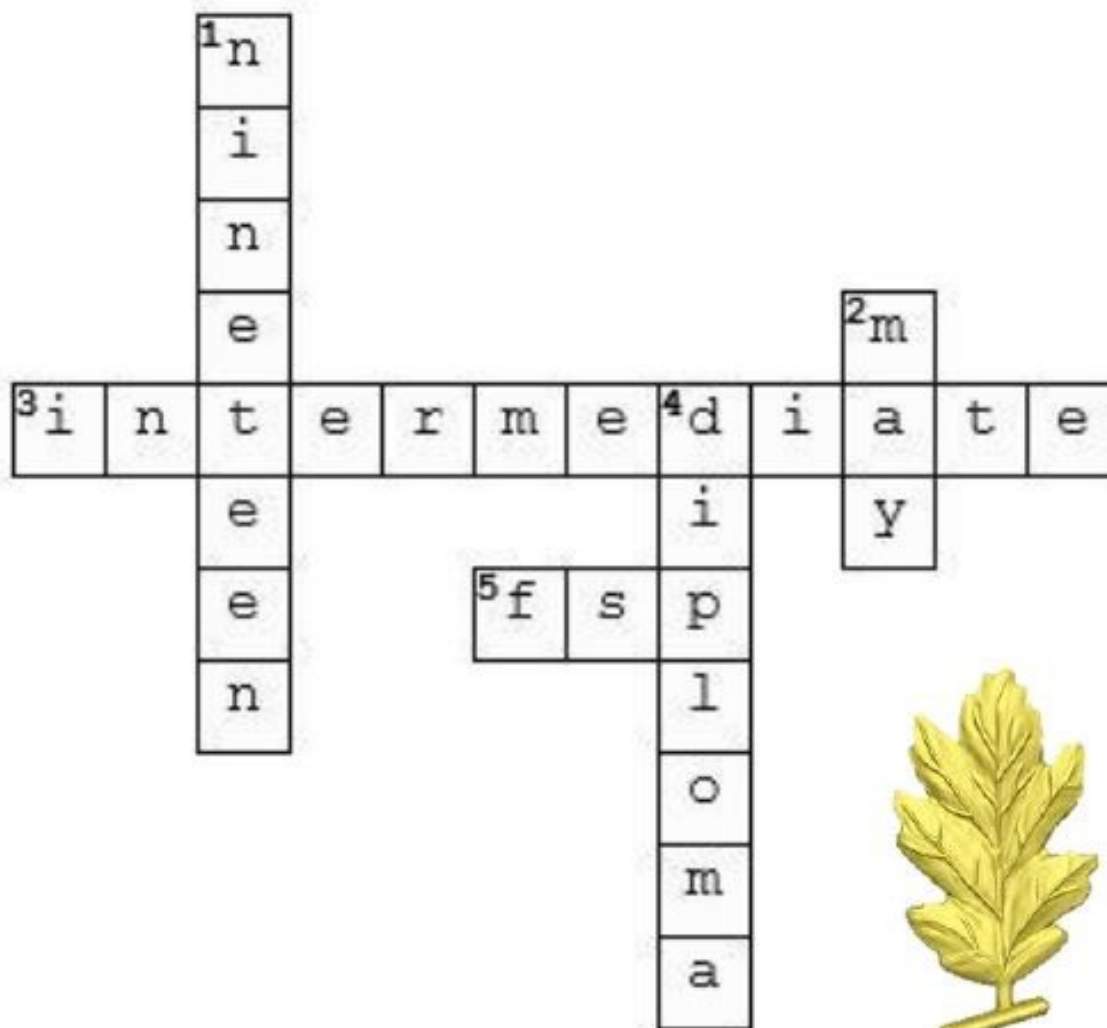
5.) NAVADMIN 141/20: Academic Year 2020-2021 Naval War College _____ (Hint: Abbreviated)

Down:

1.) Will be offered in _____ regional locations in the United States for academic year 2020-2021. (Hint: Spelled out)

2.) Each course normally requires one academic year to complete, which runs from September through the following _____.

4.) Successful completion of all three courses results in the award of a College of Naval Command and Staff _____, as well as credit for JPME-I.



June 2020 Crossword Puzzle

By: LT Rommel R. Rabulan, HCA

Across:

2.) NAVADMIN 169/20: Permanent Change of Station Post Stop Movement _____ Plan.

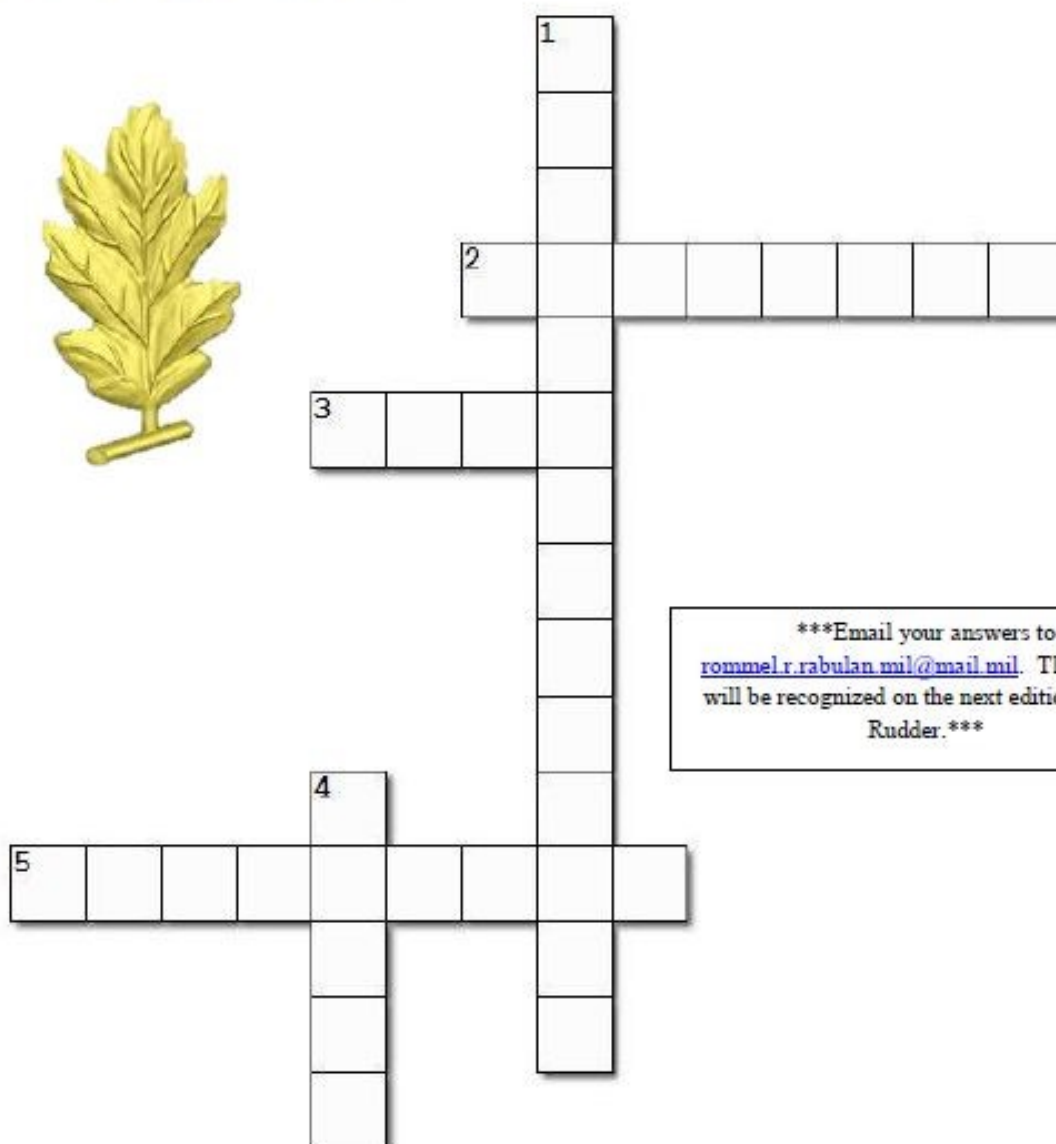
3.) Sailors transferring from high priority units will move _____.

5.) The ultimate goal is for Navy to preserve its maritime superiority by focusing on fleet _____.

Down:

1.) High priority units are those specifically designated _____ duty. (Hint: Two words, no space)

4.) Sailors transferring to high priority units will move _____.



Email your answers to rommel.r.rabulan.mil@mail.mil. The winner will be recognized on the next edition of The Rudder.

U.S. NAVY MEDICAL SERVICE CORPS

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The Medical Service Corps supports Navy Medicine's readiness and health benefits mission. It is the most diverse Officer Corps in Navy Medicine with 31 specialties organized under three major categories: Healthcare Administrators, Clinical Care Specialties, and Healthcare Scientists. There are over 3,000 active and reserve MSC officers that serve at Military Treatment Facilities, on ships, with the Fleet Marine Force, with Seabee and special warfare units, in research centers and laboratories, in a myriad of staff positions with the Navy and Marine Corps, and with our sister services around the world.

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